STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155711	A. BUILDING _____ B. WING _____	C 03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 N CAPITOL AVE INDIANAPOLIS, IN 46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00124119. This visit was in conjunction with the PSR (Post Survey Revisit) to the Investigation of Complaint IN00123130. Complaint IN00124119 unsubstantiated, allegation did not occur. This survey cycle began on 2/4/13. Survey date: March 3/6/13 Facility number: 000567 Provider number: 155711 AIM number: 100289560 Survey team: Connie Landman RN Census bed type: SNF: 4 NF: 9 SNF/NF: 24 Total: 37 Census payor type: Medicare: 6 Medicaid: 30 Other: 1 Total: 37 Sample: 0 Highland Manor was found to be in compliance with 42 CFR Part 283 Subpart B and 410 IAC	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 16.2 in regard to the Investigation of Complaint IN00124119. Quality Review completed on 03/07/2013 by Brenda Nunan, RN.	F 000		